MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes (x) No
Requestor's Name and Address Dr. B 7125 Marvin D. Love #107 Dallas, TX 75237	MDR Tracking No.: M4-04-0741-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address American Motorist Insurance Box 39	Date of Injury: Employer's Name: Insurance Carrier's No.: 00945001220

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		**CPT Code(s) or Description**	**Amount in Dispute**	**Amount Due**
From	**To**			
02/10/03	**02/10/03**	**99455-L5-WP**	**$403.00**	**$0.00**
02/24/03	**02/24/03**	**99213**	**$73.00**	**$0.00**

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary dated 08/29/03 states in part, "…We have attempted to submit our billing to the carrier for review of payment. Our second attempt was made via certified mail and to date we sill have not received a denial or payment for services rendered. According to USPS Tracing Confirmation, the carrier received our bills on 5-29-03. According to TWCC, the carrier must respond within 45days of receipt".

PART IV: RESPONDENT'S POSITION SUMMARY

The Respondent did not submit a response to the TWCC-60 or the request for additional information, signed January 4, 2005.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- CPT Codes 99455-L5-WP for date of service 02/10/03 and 99213 for date of service 02/24/03. Neither party submitted EOBs. Per Rule 133.307(e)(2)(B) the requestor did not submit convincing evidence (copy of signed green card) of the carrier's receipt of the request for reconsideration. Reimbursement is not recommended.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
2/10/2003	99455-L5-WP	$403.00	$0.00				
2/24/2003	99213	$48.00	$0.00				
					Total Left Column:		$451.00
					Total Amount Due:		$0.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to reimbursement.

Ordered by:

	Marguerite Foster	01-28-05
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____